

# EXHIBIT B

<div>1UNITED STATES DISTRICT COURT 2DISTRICT OF MASSACHUSETTS  3MAURA O'NEILL, as Administrator of 4the Estate of Madelyn E. Linsenmeir  5V. No. 20-30036-MGM  6CITY OF SPRINGFIELD, MOISES 7ZANAZANIAN, REMINGTON MCNABB, 8SHEILA RODRIGUEZ, HAMPDEN COUNTY 9SHERIFF'S DEPARTMENT, EILEEN 10BARRETT and MAUREEN COUTURE  11DEPOSITION OF: JUSTIN BERK, M.D., taken before 12Sarah L. Mubarek, Notary Public, pursuant to Rule 30 13of the Federal Rules of Civil Procedure, via 14videoconference, on March 29, 2024, commencing at 158:03 a.m.  16APPEARANCES: 17(Please see page 2)  18 19 20 21 22Sarah L. Mubarek, RPR 23Philbin &amp; Associates 2475 Market Place, Springfield, MA 01103</div>	<div>1I N D E X  2 3WITNESS: EXAMINATION PAGE 4JUSTIN BERK Direct by Mr. Day 6 5 6EXHIBITS DESCRIPTION PAGE 7Deposition 1 Berk Expert Report 49 8Deposition 2 RI DOC Alcohol Withdrawal 104 9Protocol 10Deposition 3 Linsenmeir Intake Health 164 11History 12Deposition 4 WCC Alcohol Withdrawal 181 13Protocol 14(Exhibits retained by Mr. Day.) 15 16 17 18 19 20 21 22 23 24</div>
<div>1REMOTE APPEARANCES: 2For the Plaintiff: 3American Civil Liberties Union Foundation of 4Massachusetts, Once Center Plaza, Suite 850, Boston, 5Massachusetts 02108. 6BY: DANIEL L. MCFADDEN, ESQUIRE  7For the Defendants: 8Reardon, Joyce &amp; Akerson, P.C., 4 Lancaster Terrace, 9Worcester, Massachusetts 01606, for Moises 10Zanazanian. 11BY: JOHN K. VIGLIOTTI, ESQUIRE  12Egan, Flanagan &amp; Cohen, P.C., 67 Market Street, 13Springfield, Massachusetts 01102, for Hampden County 14Sheriff's Department. 15BY: THOMAS E. DAY, ESQUIRE  16Also Present: Maura O'Neill and Noah Berthlaume 17 18 19 20 21 22 23 24</div>	<div>1S T I P U L A T I O N S 2 3It is agreed by and between the parties that 4all objections, except objections as to the form of 5the question, are reserved to be raised at the time 6of trial for the first time. 7 8It is further agreed by and between the 9parties that all motions to strike unresponsive 10answers are also reserved to be raised at the time 11of trial for the first time. 12 13It is further agreed that the deponent will 14reserve the right to read and sign the deposition 15and the sealing of said deposition will be waived. 16 17It is further agreed by and between the 18parties that notification to all parties of the 19receipt of the original deposition transcript is 20also hereby waived. 21 22 23***** 24</div>

<p style="text-align: right;">241</p> <p>1 <b>report.</b></p> <p>2 <b>Q.</b> And you're not rendering an opinion that</p> <p>3 any of the treatment with regard to opioid</p> <p>4 withdrawal at the WCC at the time that Madelyn</p> <p>5 Linsenmeir was there was improper?</p> <p>6 <b>A. I was not asked to provide an opinion on</b></p> <p>7 <b>that.</b></p> <p>8 <b>Q.</b> Okay. And you're not rendering an</p> <p>9 opinion that outside of the opioid policies,</p> <p>10 procedures and protocols, that there were other</p> <p>11 substance abuse protocols that should have been in</p> <p>12 place that were not, is that correct?</p> <p>13 <b>A. I think that that's right. I wasn't</b></p> <p>14 <b>asked to render an opinion on that, have not</b></p> <p>15 <b>rendered an opinion on that in the expert report.</b></p> <p>16 MR. DAY: If we can go off the record</p> <p>17 for just a couple of minutes, I think I can wrap up</p> <p>18 fairly quickly. My goal is to get you out of here</p> <p>19 by 5:00, Doctor.</p> <p>20 MR. MCFADDEN: All right. Why don't</p> <p>21 we come back in five.</p> <p>22 MR. DAY: Sounds good.</p> <p>23 (Brief recess is taken.)</p> <p>24 <b>Q.</b> Again, I apologize. I'm going to jump</p>	<p style="text-align: right;">243</p> <p>1 <b>Q.</b> And when you say initiate treatment for</p> <p>2 infective endocarditis, if you have a patient with</p> <p>3 infective endocarditis, are you typically going to</p> <p>4 be the doctor that handles the treatment of that</p> <p>5 patient from beginning to end?</p> <p>6 <b>A. If I am taking care of a patient with</b></p> <p>7 <b>infective endocarditis in a hospital setting, I</b></p> <p>8 <b>would be, as the hospitalist, the person arranging</b></p> <p>9 <b>the treatment, starting the treatment, taking</b></p> <p>10 <b>recommendations from the infectious disease</b></p> <p>11 <b>specialist. I would consult infectious diseases,</b></p> <p>12 <b>but yes, would start treatment.</b></p> <p>13 <b>Q.</b> In your career, how many patients have</p> <p>14 you provided treatment for with infective</p> <p>15 endocarditis?</p> <p>16 <b>A. I think it's a little tough to say, but</b></p> <p>17 <b>I'd say over the past eight years, probably between</b></p> <p>18 <b>10 and 20 patients.</b></p> <p>19 <b>Q.</b> And in any of those situations, were you</p> <p>20 the only doctor providing treatment to those</p> <p>21 patients for their infective endocarditis?</p> <p>22 <b>A. No.</b></p> <p>23 <b>Q.</b> So fair to say in every one of those</p> <p>24 situations, you had a specialist in infective</p>
<p style="text-align: right;">242</p> <p>1 around a little bit. In your report on page 12, you</p> <p>2 said, "As infective endocarditis progresses,</p> <p>3 patients will experience elevated heart rates and</p> <p>4 become febrile," correct?</p> <p>5 <b>A. That's correct.</b></p> <p>6 <b>Q.</b> And are you an expert with regard to the</p> <p>7 treatment of endocarditis?</p> <p>8 MR. MCFADDEN: Objection.</p> <p>9 <b>A. I have treated endocarditis. I have</b></p> <p>10 <b>knowledge of infective endocarditis. I would</b></p> <p>11 <b>consider myself a medical expert, but not an</b></p> <p>12 <b>infectious disease expert certainly, no.</b></p> <p>13 <b>Q.</b> But you would consider yourself a medical</p> <p>14 expert with regard to the disease infective</p> <p>15 endocarditis?</p> <p>16 <b>A. I think part of my medical training and</b></p> <p>17 <b>clinical practice is being able to identify and even</b></p> <p>18 <b>initiate treatment of infective endocarditis.</b></p> <p>19 <b>Q.</b> As an internist?</p> <p>20 <b>A. That's right.</b></p> <p>21 <b>Q.</b> And you're not an infectious disease</p> <p>22 specialist, correct?</p> <p>23 <b>A. I am not an infectious disease</b></p> <p>24 <b>specialist.</b></p>	<p style="text-align: right;">244</p> <p>1 endocarditis who was also providing treatment?</p> <p>2 <b>A. I would say specialists in infectious</b></p> <p>3 <b>disease, yes. I always had a consulting specialist</b></p> <p>4 <b>in infectious disease.</b></p> <p>5 <b>Q.</b> Is it fair to say you would never be the</p> <p>6 sole doctor treating somebody with infective</p> <p>7 endocarditis? You would always bring in a</p> <p>8 specialist?</p> <p>9 <b>A. I think that is a fair assessment to</b></p> <p>10 <b>make, yes.</b></p> <p>11 <b>Q.</b> And you state in your report, "Based on</p> <p>12 my experiences, it is my opinion that</p> <p>13 Ms. Linsenmeir's vitals would have continued to</p> <p>14 deteriorate over the course of her time at the WCC."</p> <p>15 Do you see that?</p> <p>16 <b>A. Yes.</b></p> <p>17 <b>Q.</b> And what experience is that based on?</p> <p>18 <b>A. Knowledge of the progression of infective</b></p> <p>19 <b>endocarditis, both through clinical experience, but</b></p> <p>20 <b>also knowledge of the progression of diseases like</b></p> <p>21 <b>infective endocarditis.</b></p> <p>22 <b>Q.</b> And what particular vitals would have</p> <p>23 deteriorated?</p> <p>24 <b>A. I think she would most likely be febrile</b></p>

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1 **and tachycardic or have an elevated heart rate.**

2 **Q.** Did you see any evidence in the records  
3 that she was febrile while she was at the WCC?

4 **A.** **Again, I think there was a lack of**  
5 **evidence. There was no temperature taken. There**  
6 **was no heart rate taken. I think at the time that**  
7 **EMS was called, she was diaphoretic and febrile, if**  
8 **I remember right. But there was no objective**  
9 **evidence collected regarding her vital signs during**  
10 **the four days she was there.**

11 **Q.** Did you review the medical records of the  
12 EMS providers in drafting your opinion, and in  
13 particular this opinion in the final paragraph of  
14 page 12?

15 **A.** **I feel confident that opinion in the last**  
16 **paragraph was not -- did not need to be based on the**  
17 **EMS reports, and that did not inform my opinion that**  
18 **she had infective endocarditis, and I think would**  
19 **have had worsening symptoms had anyone taken her**  
20 **vitals. She would have had worsening vital signs if**  
21 **anyone had taken her vitals.**

22 **Q.** But you didn't review the EMS records in  
23 arriving at that opinion?

24 MR. MCFADDEN: Objection.

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1 **A.** **The EMS records were not directly**  
2 **informing that opinion.**

3 **Q.** But my question was a little bit  
4 different than that, Doctor. My question is you  
5 didn't review -- did you review the EMS records in  
6 forming that opinion?

7 **A.** **Whatever I reviewed is in Exhibit B. If**  
8 **it's not listed in Exhibit B, then I did not review**  
9 **it.**

10 **Q.** Okay. In the last sentence you state,  
11 "As a result, had she received regular monitoring,  
12 her underlying pathology of infective endocarditis  
13 could have been identified in time to save her  
14 life." Are you providing an expert opinion there or  
15 is that just conjecture on your part?

16 **A.** **I would say I have a medical expert**  
17 **opinion that an individual with a severe infection**  
18 **like infective endocarditis is going to have**  
19 **clinical deterioration, as she did up until her**  
20 **death, and if you can identify it and treat it**  
21 **earlier, the likelihood of survival is far greater**  
22 **than without treatment, and that's based on my**  
23 **medical expertise. So I think that would be a**  
24 **medical opinion.**

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1 **Q.** Okay. And so is that what your medical  
2 opinion actually is?

3 **A.** **Yes, as I put in the report.**

4 **Q.** But what you just said, Doctor, is in a  
5 significant way different from that final sentence  
6 of your report. The final sentence of your report  
7 is specific to Madelyn Linsenmeir, correct? It's  
8 referring to saving her life, right?

9 **A.** **That's correct.**

10 **Q.** And what you just said, if I'm  
11 understanding you correctly, is that if you identify  
12 the symptoms of infective endocarditis and initiate  
13 treatment earlier, the chances of survival are far  
14 greater, correct?

15 **A.** **That's right, and that would apply to**  
16 **her.**

17 **Q.** That's a general statement that's not  
18 specific to Madelyn Linsenmeir, correct?

19 MR. MCFADDEN: Objection.

20 **A.** **I would say it applies to her. I would**  
21 **apply it to her, as I did in my report.**

22 **Q.** So how much earlier?

23 **A.** **I think that is a tough estimate to give,**  
24 **and I would not want to guess.**

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1 **Q.** And is it fair to say that you're not  
2 qualified to provide an opinion as to how much  
3 earlier would have saved Madelyn Linsenmeir's life?

4 **A.** **I would say it is within my scope of**  
5 **expertise to say if you treat infective endocarditis**  
6 **earlier, the mortality rate is better. I would teach**  
7 **that to medical students on rounds and feel**  
8 **comfortable with that statement. To say at what day**  
9 **does the mortality drop from a certain level to**  
10 **another is outside of my scope of expertise.**

11 **Q.** Okay. That is what you're saying in that  
12 final sentence though, right? You're not saying --  
13 I mean, it seems like you're saying two very  
14 different things. One of the things you're saying  
15 is if you catch the infection earlier, the chances  
16 of survival are greater. I don't think anybody  
17 would disagree with you on that. But that's what  
18 just said to me, right?

19 **A.** **Yes.**

20 **Q.** Okay. But then in this final sentence,  
21 you're saying something very different. You're  
22 talking about Madelyn Linsenmeir's situation  
23 specifically, and you're saying that if she had  
24 received regular monitoring of her alcohol

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1 withdrawal, her infective endocarditis would have  
2 been identified in time to save her life, right?  
3 That's what you're saying there?

4 **A. I'm saying it could have, certainly. The**  
5 **matter of days I feel confident saying can be**  
6 **significant. If a person is going to the hospital**  
7 **when they're in critical illness, they're not going**  
8 **to be doing as well as if they go to the hospital**  
9 **before they're in critical illness. I feel**  
10 **comfortable saying that. While specific hours might**  
11 **be tough, certainly I feel comfortable and it's**  
12 **within the scope of my expertise to say if someone**  
13 **was treated days before, they would do better and**  
14 **have a higher likelihood of survival.**

15 **Q.** Okay. So is what you're trying to say  
16 there in this last paragraph, that if Madelyn had  
17 been -- if her infective endocarditis had been  
18 identified earlier, she would have had a higher  
19 likelihood of survival?

20 **A. That's right. A substantially higher**  
21 **likelihood of survival, that's right.**

22 **Q.** Okay. But you're not saying that if  
23 Madelyn's infective endocarditis were identified  
24 sooner in her stay at the WCC, she would have more

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1 likely than not survived? That's not what you're  
2 saying, right?

3 MR. MCFADDEN: Objection.

4 **A. I would not be able to give the exact**  
5 **mortality benefits or exact mortality rates if it was**  
6 **one day or two days prior. If she was identified as**  
7 **having a significant illness before she was**  
8 **critically ill, I can say more likely than not, her**  
9 **treatment would be successful, and that there is a**  
10 **good chance that she would have a higher likelihood**  
11 **of mortality.**

12 **We certainly cannot predict who lives or**  
13 **dies in medicine with extreme certainty, but it is**  
14 **very clear that earlier treatment of infective**  
15 **endocarditis has improved outcomes, and that does**  
16 **not require an infectious disease fellowship to**  
17 **understand.**

18 **Q.** And I don't have any problem with that.  
19 However, what I have a problem with is that is  
20 definitely not what you're saying in this last  
21 paragraph.

22 MR. MCFADDEN: Objection.

23 **Q.** Do you agree with me?

24 **A. I would stand by what I say in the**

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1 **report. "As a result, had she had regular**  
2 **monitoring, her underlying pathology of infective**  
3 **endocarditis could have been identified in time to**  
4 **save her life."**

5 **Q.** When you say, "Could have been identified  
6 in time to save her life," that includes the  
7 possibility that it might not have been identified  
8 in time to save her life as well, correct?

9 MR. MCFADDEN: Objection.

10 **A. I cannot say that --**

11 **Q.** You're not saying it definitely would  
12 have, right?

13 **A. That's right. I wouldn't be able to**  
14 **speak in definite terms.**

15 **Q.** Okay. So then, and this is very  
16 important for an expert opinion, are you providing a  
17 likelihood there? Are you saying that -- when you  
18 say, "Could have been identified in time to save her  
19 life," are you saying that it is more likely than  
20 not that she would have survived if she had gotten  
21 regular monitoring of her alcohol withdrawal  
22 symptoms?

23 **A. I think it's tough to say. I think I**  
24 **can't say with extreme confidence. However, what I**

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1 **can say and feel strongly, is that before she was**  
2 **critically ill, if she had access to treatment for**  
3 **infective endocarditis, the survival is much better.**  
4 **More detail probably does require a subspecialist**  
5 **expert, but I feel comfortable with what I've said**  
6 **in the report.**

7 **Q.** Okay. But you don't have -- and what are  
8 you basing what you've said in that last paragraph  
9 of the report? Are you basing that on the 10 to 20  
10 patients that you've treated with infective  
11 endocarditis?

12 MR. MCFADDEN: Objection.

13 **A. I would base it not only on my clinical**  
14 **experience, but in medicine, a large part of the**  
15 **lifelong training is the study of medicine, and**  
16 **education and training, and reading about disease**  
17 **processes and discussing them in academic settings.**  
18 **There are plenty of rare diseases that people don't**  
19 **see often, but have an understanding of because, as**  
20 **physicians, we're doing a lot of training and**  
21 **education and things.**

22 **So I've seen 10 to 20 infective**  
23 **endocarditis, but have talked about infective**  
24 **endocarditis thousands of times and shared cases**

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1 **with others. So I feel comfortable about my basic**  
 2 **knowledge of infective endocarditis.**

3 **Q.** Okay. And do you base your opinion in  
 4 the final paragraph -- do you have any authority,  
 5 such as you have in other parts of your opinion, to  
 6 support that opinion? Do you have any studies, any  
 7 journal articles, anything like that?

8 **A.** **I do not in my report or in my deposition**  
 9 **now have citations or references for that statement.**

10 **Q.** Okay. Do you know how long Madelyn had  
 11 been suffering from infective endocarditis when she  
 12 arrived, as of the time that she arrived at the WCC?

13 **A.** **Based on my review of the medical**  
 14 **records, I believe she had infective endocarditis**  
 15 **the day she arrived at the WCC.**

16 **Q.** That's based on what medical records?

17 **A.** **One of the complaints of knee pain, and**  
 18 **then ultimately having septic emboli to the knee**  
 19 **from infective endocarditis is a good sign that that**  
 20 **knee pain was not from a baseball bat, but I think a**  
 21 **septic emboli from infective endocarditis.**

22 **Q.** Are there any other medical records that  
 23 you're basing that opinion?

24 **A.** **Truthfully, the major part of my opinion**

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1 **was how the alcohol withdrawal monitoring could have**  
 2 **helped identify the infective endocarditis. I**  
 3 **wasn't asked specifically as an infective**  
 4 **endocarditis expert. I would say that's where I --**  
 5 **that's the information that informed that opinion.**  
 6 **I don't know that there's more.**

7 **MR. MCFADDEN:** Tom, sorry. Can I  
 8 interject? I think there might have been a  
 9 misunderstanding on one of the questions. Were you  
 10 asking how long before Madelyn got to the WCC she  
 11 had started to have endocarditis?

12 **MR. DAY:** Yeah, I'm going to follow  
 13 up on that, Dan.

14 **MR. MCFADDEN:** I just had that  
 15 question. I'm sorry.

16 **MR. DAY:** I appreciate that. I'm  
 17 going to follow up on that.

18 **Q.** Doctor, I understand that you've provided  
 19 an opinion that Madelyn's alcohol withdrawal should  
 20 have been regularly monitored, correct?

21 **A.** **That's correct.**

22 **Q.** And you believe that's within your area  
 23 of expertise, right?

24 **A.** **That's correct.**

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1 **Q.** And you also admit that you are not an  
 2 expert with regard to infective endocarditis, right?

3 **MR. MCFADDEN:** Objection.

4 **A.** **I would say that I have some level of**  
 5 **expertise, far more than the lay person, in**  
 6 **infective endocarditis, but I am not an infectious**  
 7 **disease subspecialist.**

8 **Q.** Okay. And you're also not a lawyer, but  
 9 you understand that the statement at the end of your  
 10 report is incredibly significant to this case,  
 11 correct? You can understand that, right?

12 **A.** **And I stand by that, yes.**

13 **Q.** So in that final paragraph, you're making  
 14 a giant leap from your opinion that the monitoring  
 15 was not appropriate, to if the monitoring that I  
 16 would have liked to have seen had been done, Madelyn  
 17 would have -- Madelyn's infective endocarditis would  
 18 have been discovered in time to provide her with the  
 19 treatment that would have saved her life. I mean,  
 20 that's the leap you're making, correct?

21 **MR. MCFADDEN:** Objection.

22 **A.** **I would say that if the standard of care**  
 23 **for continued monitoring for alcohol withdrawal were**  
 24 **aligned to, I'm putting that context into it, it**

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1 **would have given an opportunity to identify a person**  
 2 **with a severe illness, who ultimately succumbed and**  
 3 **died to that severe illness, and could have not died**  
 4 **due to that illness had she had appropriate**  
 5 **monitoring.**

6 **Q.** So it's a possibility that if she had had  
 7 appropriate monitoring, they might have discovered  
 8 the infective endocarditis, and it might have been  
 9 early enough that treatment could have been  
 10 instituted, and she would not have died from the  
 11 infective endocarditis. That's what you're saying,  
 12 right? It's a possibility?

13 **MR. MCFADDEN:** Objection.

14 **A.** **I would say it's more likely than not**  
 15 **that someone's who's about to die from infective**  
 16 **endocarditis is going to demonstrate signs or**  
 17 **symptoms of infective endocarditis, which can**  
 18 **include fever, can include diaphoresis, can include**  
 19 **tachycardia. All of these things would almost**  
 20 **certainly draw a red flag if she was receiving**  
 21 **continued monitoring for underlying alcohol**  
 22 **withdrawal.**

23 **Q.** Again, I don't want to put too fine a  
 24 point on this, but this is an incredibly important

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1 point. You state that her infective endocarditis  
2 could have been identified in time to save her life.  
3 Are you saying could have been identified to a  
4 reasonable degree of medical certainty, more likely  
5 than not?

6 MR. MCFADDEN: Objection.

7 **A. I think it's tough for me to say that**  
8 **with complete confidence, though again, I think -- I**  
9 **would bet on it that I think more likely than not,**  
10 **yeah. Look. If a patient has infective**  
11 **endocarditis, they're going to have symptoms that if**  
12 **you're monitoring, you're going to pick up on.**

13 **If a patient has infective endocarditis**  
14 **and you can get earlier treatment, I don't know that**  
15 **I can say it's more likely than not they're not**  
16 **going to die, but I'd say more likely than not,**  
17 **they're going to have significantly improved**  
18 **outcomes. That I feel confident saying. I think**  
19 **that my report -- we might disagree, but I think my**  
20 **report appropriately captures that.**

21 **Q.** But you're not saying more likely than  
22 not, she would have -- Madelyn Linsenmeir would have  
23 survived if she had received regular monitoring of  
24 her alcohol withdrawal protocol after her intake at

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1 the WCC?

2 MR. MCFADDEN: Objection.

3 **A. It's tough for me to say that. I would**  
4 **lean toward, but I would defer to an infectious**  
5 **disease expert I guess. I think more likely than**  
6 **not, her outcome would have been dramatically**  
7 **improved. That I can say with unwavering**  
8 **confidence. I hesitate because you can never say**  
9 **that this person is going to live and this person is**  
10 **not. It makes for very challenging critical care**  
11 **conversations.**

12 **I did not see what she looked like. I was**  
13 **not there in the hospital. Frankly, I didn't see**  
14 **her in corrections or have any data of how sick she**  
15 **was while she was at the WCC because there was no**  
16 **vital signs, because there was no physician exam.**  
17 **So that is the barrier for me being able to say more**  
18 **likely than not she would survive. There's no**  
19 **evidence for me to understand how critically ill she**  
20 **was during the somewhat black box period that she**  
21 **was at the WCC.**

22 **Q.** Okay. But before, earlier you told me  
23 that she could have been treated at the WCC before  
24 she became critically ill, didn't you?

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1 **A. Yes. I would stand by that.**

2 **Q.** So when is that? When did she become  
3 critically ill?

4 **A. Certainly at or before taken by EMS, and**  
5 **certainly after the day she came into the WCC.**

6 **Q.** Okay. What is your basis for saying --  
7 what do you mean when you say critically ill? What  
8 does that mean?

9 **A. Having unstable vital signs is really I**  
10 **think -- they're called vital signs for that reason.**  
11 **I would say one of the biggest things is unstable**  
12 **vital signs.**

13 **Q.** Do you have any facts, other than the  
14 swollen knee, to indicate how long -- well, do you  
15 have any facts to indicate how long Madelyn  
16 Linsenmeir had been suffering from infective  
17 endocarditis as of the moment that she walked into  
18 the WCC?

19 MR. MCFADDEN: Tom, do you mean how  
20 long before the WCC she had endocarditis?

21 MR. DAY: Right.

22 **Q.** Do you have any facts, are you aware of  
23 any facts to indicate how long she had been  
24 suffering from infective endocarditis prior to

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1 walking into the WCC?

2 **A. If I recall, there was some text messages**  
3 **before going to the WCC that she feeling ill. But**  
4 **honestly, I went through the records to identify how**  
5 **the continued monitoring for alcohol withdrawal --**  
6 **how her alcohol withdrawal treatment aligned to the**  
7 **standards of care, and if it aligned to the**  
8 **standards of care that an underlying disease process**  
9 **could be identified. That's what's in my medical**  
10 **report.**

11 **Q.** Okay. And how long prior to going into  
12 the WCC were those text messages that indicated that  
13 she was feeling ill?

14 **A. I don't recall.**

15 **Q.** Okay. So at some point prior to going to  
16 the WCC, you know that Madelyn Linsenmeir was  
17 sending texts indicating that she was feeling ill,  
18 correct?

19 **A. That's right.**

20 **Q.** But in drawing this opinion, in coming to  
21 this opinion in the final paragraph of page 12, you  
22 had no idea how long before coming into the WCC  
23 Madelyn Linsenmeir had been sending text messages  
24 saying she was feeling ill?

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MR. MCFADDEN: Objection.

**A. I think that's right that I don't know when her symptoms of infective endocarditis first started. I think earlier treatment would be better. Treatment before critically ill is going to be much better than when she's critically ill.**

**Q.** So how long the infective endocarditis had been in her system makes a big difference as to her chances of survival, correct?

MR. MCFADDEN: Objection.

**A. I think that that is not necessarily true in all cases. I think treatment before critical illness is always important for improved morality outcomes. There are some infective endocarditis that are more subacute. Yeah, I would leave it at that.**

**Q.** What kind of infective endocarditis did she have?

**A. I don't know the kind of infective endocarditis that she had in that I did not review the records looking for information about infective endocarditis, but was specifically focused on the alcohol withdrawal protocol, and how monitoring especially could have identified an underlying**

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**pathology, including something like infective endocarditis.**

**Q.** And when you drafted your opinion, you didn't know what kind of infective endocarditis she had, right?

MR. MCFADDEN: Objection.

**A. When I drafted my opinion, the opinion is really identifying any other severe pathology. It didn't have to be infective endocarditis. It could have been appendicitis. It could have been sepsis from a urinary tract infection.**

**The ultimate point in the continuing monitoring is you would also certainly see abnormal vital signs or other clinical changes in someone that has a serious underlying pathology. Madelyn did have a serious underlying pathology, and the likelihood of it being caught is zero if you don't do any continued monitoring, and would have been much higher had there been continued monitoring through the alcohol withdrawal protocol.**

**Q.** Okay. But that's not an answer to my question. I apologize if I'm taking you past 5:00, but that's a great reason why right there. My question was simply that when you wrote this final

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paragraph on page 12, you didn't know what kind of infective endocarditis Madelyn had, correct?

MR. MCFADDEN: Objection.

**A. That is correct.**

**Q.** And when you wrote this final paragraph on page 12, you hadn't reviewed her hospital records to see if there's any indication there as to how far her infective endocarditis had progressed when she came to the hospital, correct?

MR. MCFADDEN: Objection.

**A. No. I had briefly reviewed the hospital records and the ID note about the infective endocarditis. I don't recall details about the infective endocarditis as that was not the core parts of the report.**

**Q.** But so whatever your review of those hospital records was, you don't remember any facts to indicate how far her infective endocarditis had progressed by the time she got to the hospital, correct?

MR. MCFADDEN: Objection.

**A. In my review of the medical records, I would say it was very clear she was very critically ill from infective endocarditis.**

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**Q.** Did you review her autopsy?

**A. I believe I reviewed the autopsy because I do remember the septic emboli into the knee as part of the autopsy.**

**Q.** But whatever your review of the autopsy was, it didn't indicate to you what kind of infective endocarditis she had?

**A. Is there a specific question? Are you asking me about the organism that caused infective endocarditis, the valve involvement?**

**Q.** What are the different types of infective endocarditis?

**A. I mean, there's different valves that can be involved. You can have mitral valve endocarditis. You can have tricuspid valve endocarditis. You can have different pathogens and bacteria that cause endocarditis. You can have complications of endocarditis; for example, septic emboli.**

**Q.** Okay. But for instance, with regard to the valves, however detailed your review of the autopsy was, you didn't learn or at least you don't know now what valves were involved, correct?

**A. That's correct. I was not, frankly,**

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1 **paying close attention to that because that was not**  
 2 **the expert opinion that was being asked of me.**

3 **Q.** Okay. You mentioned text messages. What  
 4 do you remember being said in those text messages?

5 **A. I don't recall exactly. I think it was**  
 6 **feeling sick, maybe wanting to go to the hospital.**  
 7 **A text with the mom, I believe saying, "I need to go**  
 8 **to the hospital."**

9 **Q.** And Madelyn's account of how she was  
 10 feeling, could that be an indicator of how far her  
 11 infective endocarditis had progressed?

12 **A. I would not be able to identify the**  
 13 **severity of infective endocarditis by a text**  
 14 **message, no.**

15 **Q.** And in the case of these text messages,  
 16 you don't know even when they were sent in relation  
 17 to when she got to the WCC, correct?

18 MR. MCFADDEN: Objection.

19 **A. I don't recall when they were sent.**

20 **Q.** Okay. Is one of the purposes of an  
 21 alcohol withdrawal protocol to identify infective  
 22 endocarditis?

23 **A. One of the purposes of an alcohol**  
 24 **withdrawal monitoring protocol would be to ensure**

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1 **that the alcohol withdrawal is getting better,**  
 2 **because if it's not, you would want to make sure**  
 3 **you're not missing a different diagnosis that might**  
 4 **be a severe disease process, not necessarily**  
 5 **infective endocarditis.**

6 **Q.** Does Librium address the risk of delirium  
 7 tremens?

8 MR. MCFADDEN: Objection.

9 **A. Librium can help prevent delirium**  
 10 **tremens, yes.**

11 **Q.** Does Librium address the risk of  
 12 seizures?

13 **A. Librium can help prevent specifically**  
 14 **alcohol related seizures.**

15 **Q.** And does Librium address the risk of  
 16 death from alcohol withdrawal?

17 **A. Librium can reduce the risk of death from**  
 18 **alcohol withdrawal.**

19 **Q.** In fact, addressing those three risks,  
 20 serious risks of alcohol withdrawal, are the major  
 21 reason to prescribe Librium as part of an alcohol  
 22 withdrawal program, correct?

23 **A. Yes, I would say the prevention of**  
 24 **seizures, delirium tremens and death is a major**

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1 **reason for prescribing Benzodiazepines, including**  
 2 **Librium, yes.**

3 **Q.** I just want to confirm a couple other  
 4 things that were in the DOJ report, if you still  
 5 have that pulled up.

6 **A. Sure.**

7 **Q.** So on page nine, the report reads in  
 8 part, "Housing individuals at risk for or  
 9 experiencing withdrawal in a dedicated unit or units  
 10 has several advantages, such as improved monitoring  
 11 and care (due to presence of staff with a focused  
 12 mission) efficiency of operations, (e.g. health care  
 13 staff can make rounds more quickly) and a lower risk  
 14 of diversion of treatment medications into the  
 15 general jail population." Do you see that, page  
 16 nine?

17 **A. Yes.**

18 **Q.** Do you agree with that statement?

19 **A. Yeah, to an extent, yes.**

20 **Q.** On page 30 there was some  
 21 recommendations. One of the recommendations, A24  
 22 reads, "Benzodiazepines are the preferred agent for  
 23 treating alcohol withdrawal." Do you agree with  
 24 that statement?

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1 **A. Yes, I agree with that statement.**

2 **Q.** A26 says, "Patients with CIWA-Ar scores  
 3 of less than 10 and who are at minimal risk of  
 4 developing severe or complicated alcohol withdrawal  
 5 may be provided supportive care alone and  
 6 monitored." Do you agree with that statement?

7 **A. Yes, I would agree with that statement.**

8 **Q.** Under that it reads, "It is also  
 9 appropriate to use Benzodiazepines prophylactically  
 10 for alcohol withdrawal." Do you agree with that  
 11 statement?

12 **A. Yes, I agree with that statement.**

13 **Q.** Then on A33 it reads, "Benzodiazepines  
 14 used to treat alcohol withdrawal should be tapered  
 15 and discontinued following treatment." Do you agree  
 16 with that statement?

17 **A. Yes, I agree with that statement.**

18 **Q.** Have you ever treated anyone for alcohol  
 19 withdrawal in an ambulatory setting?

20 **A. I have.**

21 **Q.** And in that situation, what do you do to  
 22 monitor that patient?

23 **A. One, we would only do it in very specific**  
 24 **circumstances; someone who is very, very low risk,**